HIGHLIGHTS:
WASTE, FRAUD & ABUSE IN THE FEDERAL HEALTH CARE SYSTEM

MEDICAID

- **Medicaid/Medicare Fraud--$53 billion in 2007 alone?**

In a March 2006 hearing chaired by Senator Coburn, experts estimated that anywhere from 3 percent to 40% of Medicaid payments are lost to "fraud and abuse." Using the federal outlay expenditures for Medicare and Medicaid in 2007 ($533 billion), and applying a low estimate of error (10%) that means that approximately **$53 billion** in taxpayers' dollars will be diverted from care for those who need it.[1]

- **New York had an estimated 42% fraud rate in 2005:**

In 2005, New York was defrauded by possibly as much as $18 billion (a fraud rate of 42% for that year in New York alone).[2]

- **Drug firm fraud may cost Medicaid untold billions**:

The nation's big drugmakers have been systematically overcharging the Medicaid health-care program for the poor, reaping billions of dollars in illegal windfalls at the expense of the taxpayers. During the past six years, about $3.9 billion has been recouped in civil damages and criminal penalties stemming from 16 legal settlements involving Medicaid.

The settlements involve some of the biggest names in the industry, including Pfizer, Schering-Plough, GlaxoSmithKline, AstraZeneca and Bayer. Those cases dealt with overcharging the government for cancer, asthma, cholesterol, allergy and seizure medications. But the scope of the problem could be much bigger: potentially billions of dollars more in pharmaceutical company fraud. There are 150 pending federal investigations centering on Medicaid and two other government health-care programs. [3]

- **$27.3 million ($15.1 million federal share) in Medicaid overpayments for services claimed to have been provided after beneficiaries' deaths:**

An audit revealed that New York State paid out $3.6 million in Medicaid claims over three years – for dead people. One nursing home collected $15,000 for a patient two years after the patient died, according to the audit by state Comptroller Alan Hevesi. The audit found payments being made for 4,277 dead patients from April 1, 2003 through February 3, 2006.

According to some news reports, the federal Center for Medicaid and Medicare Services (CMS), which oversees the programs, did not immediately know whether similar problems have cropped up in other states. The Health and Human Services Office of Inspector General (HHS, OIG) found that in 8 of the 10 States audited, providers received an estimated total of $27.3 million ($15.1 million federal share) in Medicaid overpayments – which the States never recovered – for services claimed to have been provided after beneficiaries' deaths.[4]

- **Medicaid drivers take D.C. for ride; no background checks on companies that got $22.3 million in 2005:**

City officials have recently pledged to reform the troubled program, but the lack of oversight raises questions about the overall management of the city's more than $1 billion Medicaid program. Last year, the District spent $22.3 million for nonemergency transportation of Medicaid patients – slightly more than what the city paid for patients to see individual doctors, according to city records. "There's more paid for transportation trips than doctor visits, and anybody can tell you that smells," says D.C. Council member David A. Catania, at-large independent.[5]

MEDICARE

- **Medicare fraud costs billions of dollars each year, CMS officials testify:**

The fraudulent business practices of unscrupulous durable medical equipment, orthotics, prosthetics and supplies suppliers continue to cost the Medicare program billions of dollars. Examples of fraud include paying kickbacks to physicians who prescribe high-cost wheelchairs when lower-cost equipment would be effective and filing Medicare claims for equipment never delivered or not needed. Medicare and fraud prosecutions have resulted in $11 billion in fines and settlements since 1997, according to the testimony of Daniel Fridman, senior counsel to the attorney general.[6]

- **Firm charged with Medicare fraud:**

The Federal Government charged a Florida company with fraudulently billing Medicare $170 million for infusions of HIV drugs. From roughly October 2002 through April 2006, Medicare paid more than $100 million for fraudulent services.[7]

- **Rolls Royce and $689 air mattress purchased with Medicare money:**

HHS OIG accused southern Florida health fraud gangsters of operating sham companies that submitted $142 million in bills for unnecessary or nonexistent equipment and supplies. Few if any of the products (for prosthetic limbs, costly AIDS drugs, air mattresses and urinary collection bags) were purchased or delivered to patients in need. Instead, the cash went into the pockets of company operators – one purchased a Rolls Royce Phantom valued at more than $200,000. Many of the office headquarters were found to be little more than barren storage closets. Medicare paid these individuals $689 for an air mattress.[8]

- **CMS makes $50 million mistake:**

In late August 2006, Medicare made a "data processing error" that resulted in a $50 million dollar "improper payment" when 231,000 beneficiaries wrongly received refunds (the average erroneous refund was about $215).[9]

VETERANS AFFAIRS

- **High risks in Veterans Affairs (VA) health IT projects:**

Both VA and the Department of Defense (who together coordinate health care systems for American veterans) lack detailed management plans for their health IT projects, which increases the risk of unaccountability and failure in the programs. In fact, two Government Accountability (GAO) reports use the phrase "severely challenged" when describing VA and DOD long-term efforts to provide a virtual medical record in which data are in a format that can be acted upon in real time. Both VA and the DOD have been criticized for missed milestones and major expenses related to their two newest projects, Health*e*Vet and ALHTA. Health*e*Vet in particular has received some particularly scathing reviews from independent reviewer Carnegie Mellon suggesting that the "VA faces unparalleled challenges to manage change to deliver an operationally viable [Health*e*Vet] by 2010," and that the VA's plan to spend billions to modernize the health care system that delivers services to 5 million veterans has unacceptably high risks.[10]

- **VA loses sensitive data on 2.2 million active duty military personnel:**

Social Security numbers, birthdates, names and other personal information for as many as 2.2 million U.S. military personnel (including nearly 80% of the active-duty force) were among the data stolen from the home of a Department of Veterans Affairs analyst. The department announced that personal data for as many as 1.1 million active-duty military personnel, 430,000 National Guard members and 645,000 reserve members may have been included on an electronic file stolen from a department employee's house in Aspen Hill.[11]

FEDERAL EMPLOYEE HEALTH PROGRAM

- **Over $100 million in fraud found in the Federal Employee Health Program:**

The Inspector General for the Office of Personnel Management, the federal agency that administers health benefits for government employees, found that the health benefits program was defrauded of $106 million by participating providers. According to the OIG report, the fraudulent spending came as the result of medical companies overcharging the government or arranging kickback schemes to promote the use of their products.

OPM recovered $97 million from a large settlement with one such company, and the largest case resulted in a $155 million settlement from Medco Health Solutions, which provides mail order prescriptions and related benefits to federal employees. The company settled a complaint that it paid kickbacks to health plans to gain their business, took money from drug manufacturers to favor their drugs and destroyed prescriptions to avoid penalties for delays in filling them.[12]

HIV/AIDS

- **Inspector General – $61.7 million in federal AIDS funds went unspent that could have been used to treat patients on AIDS drug waiting lists:**

An HHS OIG report reveals that bureaucratic inaction at the Health Resources and Services Administration (HRSA), not a lack of federal resources, has contributed to the patient waiting lists for AIDS drugs.

"HRSA did not use the offset authority provided by the CARE Act and HHS grants policy to manage States' unobligated balances....By doing so, HRSA would have had available a larger amount of current-year funding to address program needs. For example, the offsetting option might have been useful in grant year 2002, when 10 States had unobligated Title II balances totaling $61,723,742 and 8 States had no balances or small balances and a documented need for additional resources**.** HRSA stated that it had opted against using the offset authority provided by the CARE Act."[13]

- **Over $45 million in Title I Ryan White CARE Act funds unspent over 5 year period while AIDS patients wait for drug assistance:**

The HHS OIG issued a review of unspent Ryan White CARE Act Title I funds (AIDS care grants provided to 51 metropolitan areas in the U.S.) and found that 46 eligible areas carried over more than $45 million in unspent federal funds from two to five years beyond the original budget period between 1999 and 2003. During this period, there were hundreds of patients on waiting lists for AIDS Drug Assistance Programs throughout the country. A number of patients on these waiting lists died in South Carolina, Kentucky and West Virginia.[14]

IMPROPER PAYMENTS

- **Medicaid & the State Children's Health Insurance Program (SCHIP):**

Medicaid and SCHIP have never reported their improper payment data (both are tentatively scheduled to release their first improper payment report in 2008). Medicare and SCHIP are three years behind the requirements of the Improper Payments Information Act of 2002, which required reports from every agency on improper payment activities starting in 2004.[15]

- **Medicare:**

The fee for service component of Medicare had $10 billion in improper payments in 2006 *alone* (a 4.4% error rate). However, the Medicare Advantage and the Medicare Prescription Drug Benefit program have not reported data and have no target date to do so.[16]

OTHER WASTE, FRAUD, ABUSE & MISMANAGEMENT

- **Centers for Disease Control (CDC) can't find $22 million in equipment:**

More than $22 million worth of scientific equipment and other items is missing from the CDC, raising "troubling issues" about the Atlanta-based agency's ability to manage its property, according to members of a congressional oversight committee. There were 5,547 items of property, worth more than $22 million, unaccounted for at CDC as of February 22, 2007.[17]

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[1] "Bolstering the Safety Net: Eliminating Medicaid Fraud," Federal Financial Management Subcommittee Hearing, March 28, 2006, http://coburn.senate.gov/ffm/index.cfm?FuseAction=Hearings.Home&ContentRecord_id=47a389df-7e9c-9af9-765c-d9f650ad0d43&Issue_id=

[2] "New York Medicaid Fraud May Reach Into Billions," by Clifford Leavy and Michael Luo, *New York Times*, July 18, 2005, http://www.nytimes.com/2005/07/18/nyregion/18medicaid.html?_r=1&pagewanted=1&ei=5070&en=f58df4699f354c20&ex=1190260800&oref=slogin

[3] "Drug firm fraud may cost Medicaid untold billions: Officials say companies systematically overbill health agency for poor," by Robert Cohen, *Newhouse News Service*, February 22, 2007, http://www.calnurses.org/media-center/in-the-news/2007/february/page.jsp?itemID=29557755

[4] "Audit of Selected States' Medicaid Payments for Services Claimed To Have Been Provided to Deceased Beneficiaries," report by Health and Human Services Deputy Inspector General Joseph Vengrin, September 26, 2006, http://oig.hhs.gov/oas/reports/region5/50500030.pdf

[5] "Medicaid drivers take D.C. for ride," by Jim McElhatton, *The Washington Times*, October 23, 2006, http://goliath.ecnext.com/coms2/gi_0199-5869427/Medicaid-drivers-take-D-C.html#abstract

[6] "Medicare Fraud Costs Billions of Dollars Each Year, CMS Officials Testify," *Kaiser Daily Health Policy Report*, April 19, 2007, http://www.kaisernetwork.org/daily_reports/rep_index.cfm?DR_ID=44358

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[9] "'Data Processing Error' Was a Medicare Slip-Up: 231,000 Beneficiaries Wrongly Received Refunds," by Christopher Lee, *Washington Post*, August 24, 2006, http://www.washingtonpost.com/wp-dyn/content/article/2006/08/23/AR2006082301669.html?referrer=email&referrer=email&referrer=email; and "Lawsuit blocks CMS repayment campaign," by Jeffrey Young, *The Hill*, September 19, 2006, http://thehill.com/leading-the-news/lawsuit-blocks-cms-repayment-campaign-2006-09-19.html

[10] "Coburn Examines Hold-up in Advancement of Critical Health Information Technology," Federal Financial Management Subcommittee Hearing, June 22, 2006, http://coburn.senate.gov/ffm/index.cfm?FuseAction=Hearings.Home&ContentRecord_id=eccd8f13-802a-23ad-4300-f94bb63c5891&Issue_id=

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[12] "Auditors uncover fraud in federal benefit programs," by Brittany R. Ballenstedt, *Government Executive*, June 18, 2007, http://www.govexec.com/story_page.cfm?articleid=37230&dcn=todaysnews

[13] "Review of the Management of Unobligated Funds Provided By Title II of the Ryan White CARE Comprehensive AIDS Resources Emergency Act," by Health and Human Services Inspector General Daniel R. Levinson, May 15, 2007, http://coburn.senate.gov/ffm/index.cfm?FuseAction=Files.View&FileStore_id=f42602d4-61eb-49d7-a14e-c63d82ddf935

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[15] Ibid.

[16] Ibid.

[17] "CDC Lost $22 Million Worth Of Computers And Equipment," by Sharon Gaudin, *InformationWeek*, July 13, 2007, http://www.informationweek.com/story/showArticle.jhtml?articleID=201001314